24.0.0 BENEFITS

24.1.0 Introduction
24.1.1 Benefit

MA covers many health care services. However, limitations apply that ensure that only medically necessary services are provided.

24.2.0 Full-Benefit MA

Those subprograms of MA that are eligible to receive full-benefit MA services include:

- Katie Beckett Medicaid (19.6.0).
- Community Waivers Medicaid (25.0.0).
- Institutions Medicaid (10.0.0).
- AFDC-Medicaid (cat needy).
- Medicaid Extension (earnings/hours/loss of disregard) (9.0.0).
- AFDC-Related Medicaid (cat or med needy).
- EBD Medicaid (cat or med needy).
- Continuously Eligible Newborn (CEN) Medicaid (26.5.0).
- Healthy Start for OBRA Kids (26.5.4).
- Healthy Start for Children Under 6 (cat or med needy) (26.5.3).
- Healthy Start for Pregnant Women (26.5.1).
- 60-Day End-of-Pregnancy Extension (9.5.0).
- Foster Care Medicaid (13.0.0).
- Adoption Assistance Medicaid.
- Medicaid Met Deductibles (20.8.0).
- Medicaid Purchase Plan (MAPP) (33.0.0).
- BadgerCare (12.0.0).
- Wisconsin Well Woman Medicaid (39.0.0).

24.3.0 Limited Benefit MA

Limited benefit subprograms of MA includes:

- Medicare Buy-In Programs (27.0.0).
- Emergency Services for Non-Qualifying Aliens (2.3.0).
- Tuberculosis-Related MA (19.7.0).
- Presumptively Eligible Pregnant Women (26.4.0).
- Family Care Non-MA (32.3.0).
- SeniorCare (41.0.0)
- Family Planning Waiver (42.0.0)

24.4.0 Covered Services

A covered service is any medical service that MA will pay for an eligible client, if billed. The Division of Health Care Financing (DHCF) certifies qualified health care providers and reimburses them for providing MA covered services to eligible MA clients. Clients may receive MA services only

24.4.0 Covered Services (cont.)

from MA certified providers, except in medical emergencies. MA reimburses emergency medical services necessary to prevent the death or serious impairment of the health of a client even when provided by a non-certified provider.

MA providers must submit a prior authorization request to the Medicaid fiscal agent before providing certain MA services.

Examples of MA covered services include:

- Case management services.
- Chiropractic services.
- Dental services.
- Family planning services and supplies.
- Federally Qualified Health Center (FQHC) services.
- HealthCheck (Early and Periodic Screening, Diagnosis and Treatment – ESPDT) of people under 21 years of age.
- Home and community-based services authorized under a waiver.
- Home health services or nursing services if a home health agency is unavailable.
- Hospice care.
- Inpatient hospital services other than services in an institution for mental disease.
- Inpatient hospital, skilled nursing facility, and intermediate care facility services for patients in institutions for mental disease who are:
  - under 21 years of age.
  - under 22 years of age and received services immediately before reaching age 21.
  - 65 years of age or older.
- Intermediate care facility services, other than services at an institution for mental disease.
- Laboratory and X-ray services.
- Legend drugs and over-the counter drugs listed in Wisconsin Medicaid's drug index.
- Medical supplies and equipment.
- Mental health and medical day treatment.
- Mental health and psychosocial rehabilitative services, including case management services provided by the staff of a certified community support program.
- Nurse midwife services.
- Nursing services, including services performed by a nurse practitioner.
- Optometric or optical services, including eyeglasses .

24.4.0 Covered Services (cont.)

- Outpatient hospital services.
- Personal care services.
- Physical and occupational therapy.
- Physician services.
- Podiatry services.
- Prenatal care coordination for women with high-risk pregnancies.
- Respiratory care services for ventilator-dependent individuals.
- Rural health clinic services.
- Skilled nursing home services other than in an institution for mental disease.
- Speech, hearing, and language disorder services.
- Substance abuse (alcohol and other abuse services).
- TB (tuberculosis) services.
- Transportation to obtain medical care.

If you or the client have additional questions, contact Recipient Services at 1-800-362-3002.

24.4.1 Transportation

Federal regulations require that MA programs provide transportation to clients who need to obtain MA services. Transportation by ambulance, specialized medical vehicle (SMV) or ESA approved common carrier is a covered MA service when provided in accordance with the appropriate sections below.

24.4.1.1 Ambulance

Ambulance transportation is a covered service if it is provided by a MA certified ambulance provider, and the client is suffering from an illness or injury that rules out other forms of transportation, and only if it is for:

- Emergency care when immediate medical treatment or mexamination is needed to deal with or guard against a worsening of the person's condition.
- Non-emergency care when authorized in writing by a physician, physician assistant, nurse midwife or nurse practitioner.

ES is not responsible for prior authorization for ambulance services.

24.4.1.2 Specialized Medical Vehicle (SMV)

A Specialized Medical Vehicle (SMV) is a vehicle equipped with a lift or ramp for loading wheelchairs. The driver of a SMV must have first aid training and CPR certification.

SMV transportation is a covered service if the person is legally blind, or indefinitely or temporarily disabled as documented in writing by a physician, physician assistant, nurse midwife, or nurse practitioner. The documentation from the provider must indicate why the person's condition prevents him/her from using a common carrier or private vehicle. In the case of a temporary disability, the documentation must indicate the expected length of time SMV services will be necessary, as well as why the person cannot use common carrier transportation.

SMV services are available only for transportation to a MA covered service (including community waiver services if transportation is included in the per diem). A client's age, place of residence, lack of parental supervision, or lack of a driver's license are not qualifying criteria for SMV services.

ES is not responsible for prior authorization for SMV services, but may refer a client who is unable to use common carrier to a MA certified SMV provider.

Managed Care
MA HMOs and special managed care programs authorize and reimburse transportation providers for ambulance and specialized medical vehicle services. Care Management Organizations (CMOs) do not cover common carrier or ambulance service, but do contract for SMV services. If a client is not in a HMO, s/he can call 1-800-362-3002 with questions on ambulance or SMV providers.

24.4.1.3 Common Carrier

Common carrier means any mode of transportation approved by an Economic Support Agency (ESA), except an ambulance or a SMV. Common carrier transportation is a covered service if the ESA (or a designated agency) authorizes the transportation.

Transportation to Out-of-State Providers
Except for services provided by MA-certified "border-status" providers, all non-emergency out-of-state services require prior authorization from the MA program. According to s. HFS 101.03, a border-status provider is, "a provider located

24.4.1.3 Common Carrier (cont.)

outside of Wisconsin who regularly gives service to Wisconsin recipients and who is certified to participate in MA."

If the MA program approves a request for out-of-state health care services, the transportation to receive the service may be covered if authorized by the ESA. The ESA may approve a request for the transportation only if prior authorization has been granted for the health care service that the recipient will be receiving from the out-of-state provider. The ESA should not approve requests for out-of-state transportation if the MA program has not authorized the out-of-state health care service.

As with other travel, approve the least expensive means of transportation, which the client can use, and which is reasonably available when the service is required. The ESA may provide reimbursement up to the charges of the common carrier, for mileage expenses or a contracted amount the ESA or its designated agency has agreed to pay the transportation provider. Related travel expenses may be covered as described below. The ESA may request verification of expenses, or documentation that the trip occurred.

Transportation Administration
When providing common carrier transportation, the ESA should use the most cost-effective mode of transportation possible. The ESA reimburses transportation by common carrier. Clients may contact the ESA with questions on common carrier reimbursement.

Common carrier transportation requires authorization by the county/tribal agency prior to departure. The client or someone acting on his/her behalf may request the authorization. The request can be made by phone, in person, or in writing to the ESA. Denials must be in writing and must explain why the request was denied. The county/tribal agency may delegate common carrier authorization to another county/tribal, or other local agency, provided clients are assured of transportation to MA covered services.

Issue authorizations and denials with reasonable promptness. For authorizations, specify the means of transportation authorized. If recurring medical care is needed, you may authorize all of the trips needed for a specific time period.

24.4.1.3 Common Carrier (cont.)

Reimbursement

Follow these guidelines when approving or reimbursing transportation services:

1. Approve the least expensive means of transportation, which the client can use, and which is reasonably available when the service is required. If neighbors, friends, relatives or voluntary organizations have routinely provided transportation at no cost, the county or tribal agency does not have to approve that transportation.
2. Do not restrict approval according to the type of covered service. For example, you may not limit reimbursement for transportation to only urgent medical services or physician provided services.
3. Reimburse transportation only to and from a location where the client receives a MA covered service.

   The ESA may request documentation that a MA covered service was provided:

   - If provision of covered services is questionable or
   - The client was unable to obtain prior approval.
4. The county/tribal agency may limit reimbursement for mileage to the nearest provider if the client has reasonable access to health care of adequate quality from that provider.

   Example. There is a pharmacy 11 miles from the client's home that could have filled his/her prescription. But s/he went to one 32 miles from home. Reimburse him/her on the basis of the shorter distance. The county or tribal agency may require provider documentation of the need for a specialized service at the location requested.
5. The ESA may reimburse clients who use their own vehicle up to $0.24 a mile, and may bill up to $0.26 a mile and keep up to $0.02 a mile for administration.

   If the vehicle is lift/ramp equipped, you may reimburse up to $0.50 a mile. The ESA may bill $0.52 a mile and keep up to $0.02 a mile for administration.
6. A volunteer driver (someone who provides service to another person) may be reimbursed up to $0.33 a mile.

24.4.1.3 Common Carrier (cont.)

If they carry more than one client on a single trip, volunteer drivers may be reimbursed up to $0.35 a mile. The county or tribal agency may bill up to $0.36 a mile ($0.38 for more than one client on a single trip) and keep up to $0.03 a mile for administration.

7. You may reimburse public carriers, such as taxis and buses for non-contracted trips, up to their usual and customary charges to the general public. Reimburse the provider directly, or have the client pay for the transportation and reimburse him/her.

8. When no alternative transportation arrangements are available or when it is the most cost effective alternative, the ESA may contract with SMVs or Human Service Vehicles (HSVs).

   Limit reimbursement to no more than $1.05 per loaded mile for each client. Loaded mileage is the mileage driven when the client is on board.

   When an agency contracts with a SMV, HSV, taxi company or similar entity, the agency may charge administrative costs of up to five percent of the amount paid. The amount paid must not exceed $1.05 per loaded mile for each client.

9. County or tribal agencies may operate their own program to transport clients. They may claim reimbursement as follows:

   - Car. Up to the rate per mile allowed for state employees who use their own car, and keep up to 3 cents per mile for administration.

   - Van. Up to $.0.50 per mile and keep up to $0.05 per mile for administration. If the agency hires a driver for transporting clients exclusively, it may claim up to $1.05 per mile. Do not claim additional amounts for the driver's salary or for administrative expenses.

   For the most current state rates, refer to http://www.dhfs.state.wi.us/bfs/pdf/APP/Travel/trav10.pdf. The information in this page should be updated annually.

10. The county or tribal agency may not use common carrier transportation funds to pay drivers while they are

24.4.1.3 Common Carrier services. Do (cont.)

not actively providing direct transportation

not claim reimbursement for the cost of purchasing the vehicle.

11. The county or tribal agency may cover travel-related expenses if the travel is "other than routine." Travel that is other than routine may be defined as trips that are significantly beyond the distances typically traveled to obtain health care services in a particular locality.

    Related travel expenses may also include the cost of meals and commercial lodging en route to and from, and while receiving, a MA-covered service. Related travel expenses may also include the cost of an attendant to accompany the client if, the client's age and/or physical condition warrants an attendant. If the client is age 16 years or older, the need for an attendant must be determined and documented in writing by a physician, physician assistant, nurse midwife, or nurse practitioner.

    Only reimburse the cost of one attendant, unless the physician, physician assistant, nurse midwife, or nurse practitioner documents in writing, that the recipient's condition requires the physical presence of more than one attendant. The ESA or its designated agency must maintain the statement of need.

12. An attendant is a person, in addition to the driver, that is specifically trained in procedures that are necessary for care and transportation of the client. An attendant's costs may include transportation, lodging, meals, and a salary.

    When the attendant is a member of the client's family, limit reimbursable costs to transportation, commercial lodging and meals. A client's family consists of the client, his/her spouse, parent, stepparent, foster parent, half-siblings, the client's natural, adoptive, and stepchildren, grandparent, and grandchildren.

    County/tribal agencies may approve up to four weeks of expenses without DHFS approval. A request for attendant care over four weeks requires prior authorization by DHFS. Send prior authorization requests to:

24.4.1.3 Common Carrier (cont.)

Transportation Policy Analyst
Division of Health Care Financing
P.O. Box 309
Madison, WI 53701-0309

Reimbursement for the client's and/or attendant's meals and lodging must be no greater than the amounts paid by the state to its employees for those expenses. Reimburse multiple night stays at state rates for employees. The minimum salary for an attendant must be the minimum federal hourly wage.

For the most current state rates, refer to http://www.dhfs.state.wi.us/bfs/pdf/APP/Travel/trav10.pdf . The information in this page should be updated annually.

13. The county/tribal agency may establish their own procedures for cash advances to clients.

14. Apply these reimbursement guidelines for clients who are retroactively certified for MA. They are entitled to request reimbursement of medical transportation costs that occurred during the retroactive period.

15. Medicare beneficiaries who are ineligible for MA are not eligible for MA transportation reimbursement.

16. For common carrier transportation, MA will reimburse ESA's for transportation costs that have prior authorization. The ESA may also work with an HMO to coordinate the common carrier transportation.

    MA encourages ESA's that choose not to contract with an HMO for transportation to work with the HMO so that the enrollee's transportation needs can be met.

Transportation Waiver
When you deny a request for transportation expenses, tell the client that s/he can ask for a waiver. If s/he asks for a waiver, write up the waiver request.

In your waiver request:

1. Refer to the Administrative Rule permitting waivers (HFS 106.13).

24.4.1.3 Common Carrier (cont.)

2. If the denial is for a family member's attendant services, note the waiver request is to waive Administrative Rule HFS 107.23 (3).
3. Describe the specific case situation.
4. Give your reason(s) for requesting the waiver. An example of a reason would be that enforcement of the requirement would result in unreasonable hardship for the person.
5. Sign the request and send it to:

   Transportation Policy Analyst
   Division of Health Care Financing
   P.O. Box 309
   Madison, WI 53701-0309

24.5.0 Co-Payment

Clients are responsible for making a co-payment for many medical services and procedures. Children less than 18 years of age, nursing home residents and people in state-contracted or other MA managed care programs receiving managed care covered services are exempt from co-payments.

Medical services exempt from co-payments are:

1. Emergency hospital and ambulance services and emergency services related to the relief of dental pain.
2. Services related to pregnancy.
3. Family planning services and supplies.
4. Common carrier transportation, if provided through or paid for by a county/tribal human or social services department.
5. Home health services.
6. Personal care services.
7. Case management services.
8. Outpatient psychotherapy services received that exceed 15 hours or $500, whichever occurs first, during one calendar year.
9. Occupational, physical, or speech therapy services received that exceed 30 hours or $1,500 for any one therapy, whichever occurs first, during one calendar year.
10. Hospice care services.
11. Substance abuse (alcohol and other drug abuse) day treatment services.
12. Respiratory care for ventilator-assisted clients.

24.5.0 Co-Payment (cont.)

13. Community Support Program (CSP) services.

Providers are required to make a reasonable effort to collect the co-payment. Co-payments range from $0.50 to $3.00 for each procedure or service. Providers may not refuse services to a client who fails to make a co-payment.

24.6.0 HMO Enrollment

Most MA clients who are eligible for Family MA and reside in a MA HMO service area must enroll in a HMO.

Clients may choose their own HMO or work with the HMO Enrollment Specialist to choose the best one for their needs. They may choose at any time during the enrollment process. All eligible members of the client's family must choose the same HMO. However, individuals within a family may be eligible for exemption from enrollment.

This is the enrollment process:

1. Clients residing in a HMO service area receive a HMO enrollment packet. The packet has an enrollment form, a list of available HMOs, instructions on how to choose a HMO and how to find out if a provider is affiliated with a HMO.

2. If the client does not choose a HMO within two weeks of receiving the enrollment packet, s/he receives a reminder card. Clients in areas with only one available HMO will stop here in the process. They do not have to enroll in a HMO.

3. If the client has not chosen a HMO after four weeks, and lives in an area covered by two or more HMO's, s/he will be assigned a HMO. A letter explaining the assignment will be sent to him/her. S/he will receive another enrollment form and have an opportunity to change the assigned HMO.

4. S/he will then receive a notice confirming enrollment in the assigned or chosen HMO for the following month. The client has up to three months to change HMOs, once enrolled. This is the open enrollment period. After the initial three months, the client is locked into the HMO and cannot change for nine months. If your client has questions about HMO enrollment, s/he should contact the Enrollment Specialist at 1-800-291-2002.

24.6.0 HMO Enrollment (cont.)

Exemptions: A client may qualify for an exemption from HMO enrollment if they meet certain criteria, such as a chronic illness, high-risk third trimester pregnancy, or continuity of care concerns, etc.

If the client believes s/he has a valid reason for exemption, s/he should call the HMO Enrollment Specialist at 1-800-291-2002. The number is also in the enrollment materials they receive.

24.6.1 Change of Circumstances

Clients who lose MA eligibility, but become eligible again within six months, may be automatically re-enrolled in their previous HMO.

If the client's eligibility is re-established after the six-month period, s/he will be automatically re-enrolled in the previous HMO, unless the HMO is no longer accepting reassign-ments.

After six months, or if the HMO is no longer accepting reassignments or has exceeded its enrollment level, s/he will receive an enrollment packet, and the enrollment process will start over.

24.6.2 Disenrollment

Clients are automatically disenrolled from the HMO program if:

1. Their medical status code changes to a non-Family MA subprogram.
2. They become eligible for Medicare.
3. They lose eligibility.
4. They move out of the HMO's service area.

Clients who move out of the HMO service area receive a new packet showing the HMO(s) available in the new area and the enrollment process begins again. If no HMO covers the client's new area, s/he remains fee-for-service.

24.6.3 EDS Ombuds

Clients with questions about their rights as HMO enrollees may call 1-800-760-0001 or write:

HMO Ombuds
P.O. Box 6470
Madison, WI 53791-9823

24.7.0 Medicaid Cards

Forward cards are issued to MA clients. These cards are blue, permanent, plastic, and display the word “Forward” on them. Clients use the same Forward card each month. Monthly cards are not issued.

Each person in the family who is eligible for MA receives his/her own card. The cards do not display eligibility dates. All MA services are paid for under the MA ID number on the card. For newborns that do not have a MA ID, MA pays for all services within the first ten days of the baby's birth under the mother's MA ID number. The baby need not be determined eligible for the claims to be paid. If the baby has a MA ID, services are billed under that number. If the baby does not have a MA ID, CARES will assign a pseudo ID number. EDS assigns a pseudo ID if the newborn is reported to them by a MA HMO or hospital, and the newborn has not yet received an SSN.

Clients will know if they are eligible based on positive and negative notices sent from the ESA. Clients who receive a notice that they are no longer eligible for MA should keep their Forward cards. Cards should not be thrown away. If a client becomes eligible again, they will use the same Forward card originally issued. If they have questions regarding their eligibility status, they can call you or Recipient Services at 1-800-362-3002.

24.7.1 Appeals

Keep an MA case in appeal status open if the client makes a request prior to the closure date. The client can continue to use their Forward card until a decision is made regarding his/her eligibility.

24.7.2 Homeless

Make ID cards available to homeless MA clients who have no fixed address or mailing address. Use your agency address or some other fixed address for delivery.

24.7.3 Lock-in Program

A program called ‘Lock-in’ is available in cases of benefit misuse. The client is assigned to a particular provider for services. When a client receives health care, the providers are told of the client’s restriction(s) when verifying eligibility. If you have information that your client may be misusing benefits or his/her Forward card, send the client’s name, address, card number, and a summary of the facts and any documentation to:

24.7.3 Lock-in Program (cont.)

Division of Health Care Financing
Bureau of Health Care Program Integrity
P.O. Box 309
Madison, WI 53701-0309

Or call providers services at (800) 947-9627 or (608)221-9883 .

24.7.4 Temporary Cards

The following cards are the only paper MA cards:

- Green Cards
- Tan Cards

24.7.4.1 Green Cards

EDS does not issue temporary cards. The Economic Support Agency (ESA) issues them. Each agency must issue a temporary card if the client does not already have a Forward card and needs health care within the two to three days before s/he receives one in the mail. The green temporary card is the only way the client may be able to receive services without having to pay out-of-pocket, since eligibility is not on MMIS yet for the provider to verify.

Order the green temporary MA ID card stock from:

Medicaid Eligibility Maintenance
P.O. Box 7636
Madison, WI 53707-7636

Phone: (608) 221-4746

Fax: (608) 221-0885

When ordering, indicate the agency, contact person, and number of blank cards desired.

Include the following on each temporary ID card you issue:

1. MA ID number.
2. Agency code.
3. Medical status code.
4. Client's full name.
5. Client's date of birth.
6. Client's sex (M or F).
7. Client's address.
8. Valid dates: Do not use future dates beyond the current benefit month.

24.7.4.1 Green Cards (cont.)

9. Other insurance coverage. If private insurance, include the name. If Medicare, include the Medicare number as it appears on the client's Medicare card with "A" for Part A and/or "B" for Part B.

Do not issue a temporary card to clients who would not normally receive a Forward card. Clients in the following categories do not get a Forward card, so should not be issued temporary cards:

- AE – Alien Emergency services. No card is necessary because only services directly related to the emergency are reimbursable by MA.
- FC - Family Care Non-MA. MA does not cover services provided to clients in this category. If the client is enrolled in a Family Care CMO, limited services are provided entirely by that CMO.
- Medicare Premium Assistance Programs
  - SB – SLMB only
  - SLMB+ – Qualified individual, group 1
  - ALMB – Qualified individual, group 2
  - QW – QDWI

  MA pays for these clients' Part A and/or Part B Medicare premiums. No health care services are payable by MA.

24.7.4.2 Tan Cards

Temporary tan cards are provided to the client from the PE provider after having completed a presumptive eligibility application and the provider has found the client eligible for PE. The provider sends the completed PE application to EDS. Once EDS receives the PE application from the provider and applies the PE eligibility to MMIS, a Forward card is sent to the client.

24.7.5 Lost/Stolen Cards

If a client needs a replacement card, s/he or an authorized representative, including ES, should call Recipient Services at 1-800-362-3002. A new Forward card will be issued and will be sent out the following business day. The 16-digit number on the card is unique to each card. If a new card is issued, it will have a new card number to help prevent fraud and monitor card stock.

24.7.5 Lost/Stolen Cards (cont.)

Replacement cards are issued automatically when:

1. The client's name changes.

2. The card was returned as undeliverable and the client's address changes.

A replacement for any other reason must be requested through Recipient Services, 1-800-362-3002.

You cannot request replacement cards using a DES 3070 or CARES.

24.8.0 Waiver of MA Benefit Limitations

Someone who is eligible for MA but has been refused a specific MA benefit by the provider can be given a waiver. The waiver lifts the limitation and allows the client to receive the benefit.

The provider of the service must request the waiver. The request goes to the Division of Health Care Financing (DHCF).

24.9.0 Third Party Coverage

See Appendix 38.0.0.